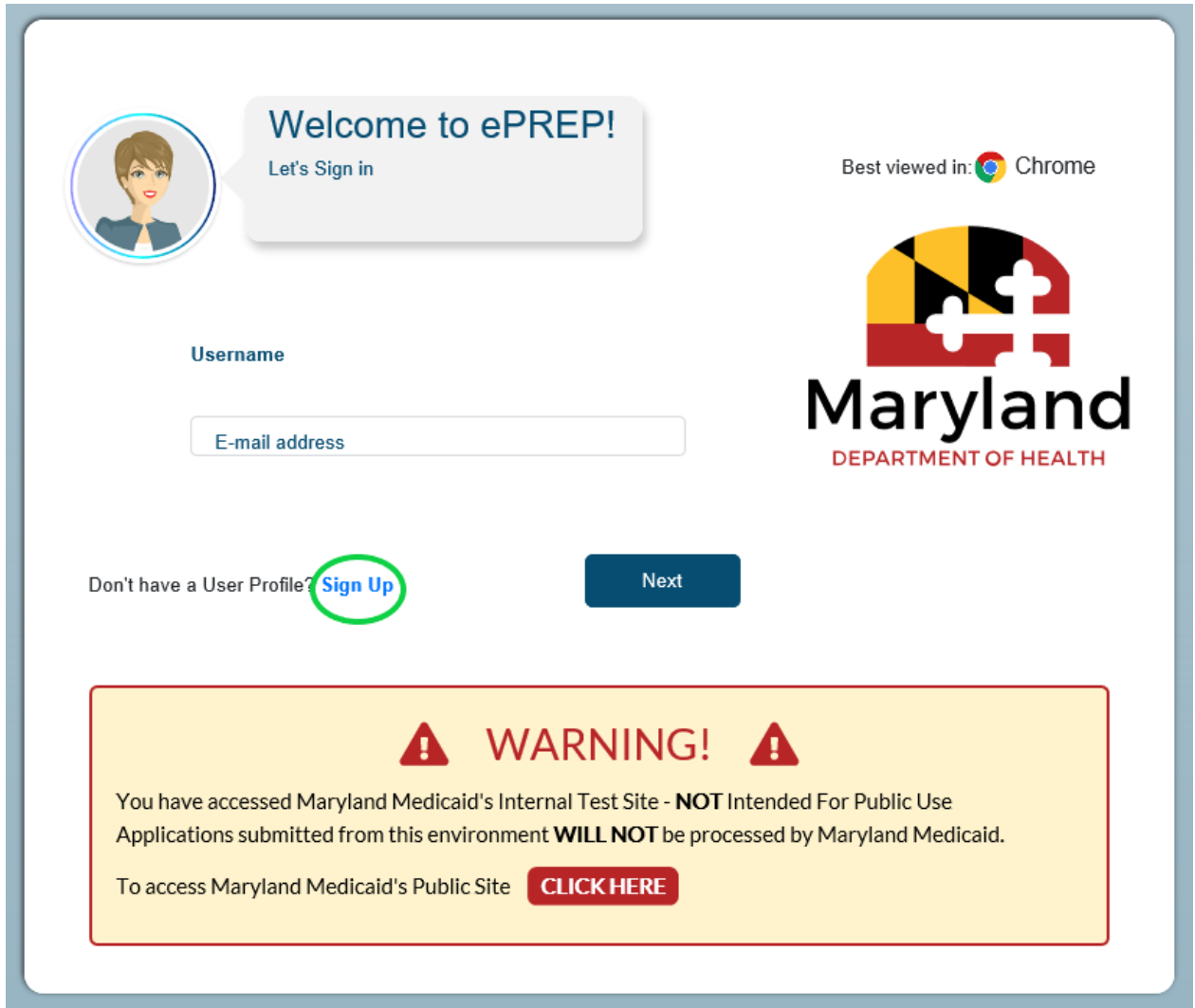





Welcome to the e PREP provider portal page!

1. New providers / groups enrolling with Maryland Medicaid for the first time will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:



 **Welcome to ePREP!**
Let's Sign in

Best viewed in:  Chrome


Maryland
DEPARTMENT OF HEALTH

Username

E-mail address


Don't have a User Profile? [Sign Up](#) [Next](#)

WARNING!

You have accessed Maryland Medicaid's Internal Test Site - **NOT** Intended For Public Use
Applications submitted from this environment **WILL NOT** be processed by Maryland Medicaid.

To access Maryland Medicaid's Public Site [CLICK HERE](#)

2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.



Welcome to ePREP!

My name is Lucy. I'm here to help you create your ePREP User Profile. This profile allows you to securely login to the ePREP Portal at any time (24/7) from an up-to-date web browser: Chrome, Firefox, Safari, IE Explorer.

Let's get started!

First name

Last name

Username


Password

Confirm

Phone number

Recovery email address


This reCAPTCHA is for testing purposes only. Please report to the site admin if you are seeing this.



I'm not a robot


reCAPTCHA
Privacy - Terms

By selecting Next, you agree to the [Terms and Conditions](#).

Best viewed in:  Chrome

NEXT

3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next'.



We have increased our security levels and need to **verify** your device.

Choose an [option below](#) to receive your security code.

Once you receive the code, you will enter it here in ePREP before you can login.

☒

 Send text message to my phone number

☐

 Call my phone number


☐

 Send to my recovery email address

BACK

NEXT

4. Please enter your 6 digit authentication code and click 'Verify'.




I'm sending you the verification code to this location. This code will expire in 90 minutes. This code can only be generated up to 5 times within a 24 hour period.

The verification code has been sent to your [Phone Number](#):


(410) .

ePREP- Enter 6 digit Verification Code

[BACK](#) [CALL INSTEAD](#) [VERIFY](#)



You did it!

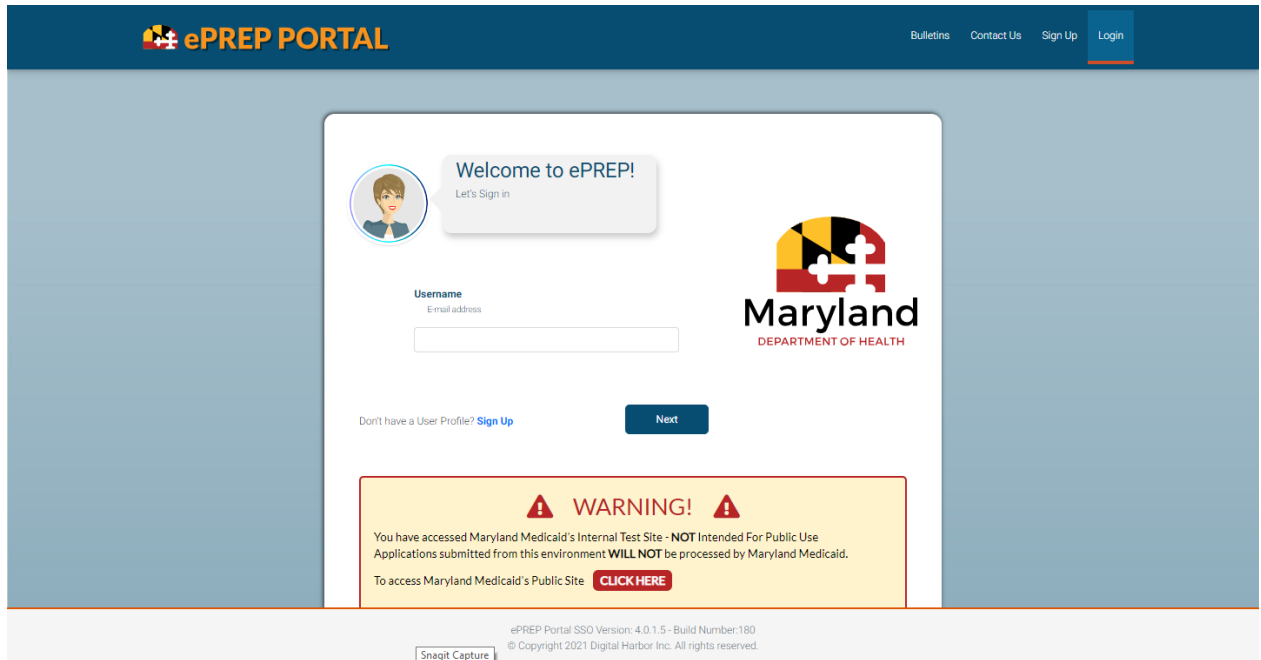


Success

Select [Login](#) to continue

[LOGIN](#)

5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.



The screenshot shows the ePREP PORTAL login interface. At the top, there is a dark blue header with the ePREP PORTAL logo on the left and navigation links (Bulletins, Contact Us, Sign Up, Login) on the right. The main content area is white and features a 'Welcome to ePREP!' message with a 'Let's Sign in' button. Below this is a login form with fields for 'Username' and 'Email address'. To the right of the form is the Maryland Department of Health logo. A 'Next' button is located below the form. A yellow warning box at the bottom of the form states: 'WARNING! You have accessed Maryland Medicaid's Internal Test Site - NOT Intended For Public Use. Applications submitted from this environment WILL NOT be processed by Maryland Medicaid. To access Maryland Medicaid's Public Site, CLICK HERE.' At the very bottom, there is a footer with version information and a 'Snagit Capture' watermark.

ePREP PORTAL

Bulletins Contact Us Sign Up Login

Welcome to ePREP!
Let's Sign in

Username
Email address

Don't have a User Profile? [Sign Up](#)

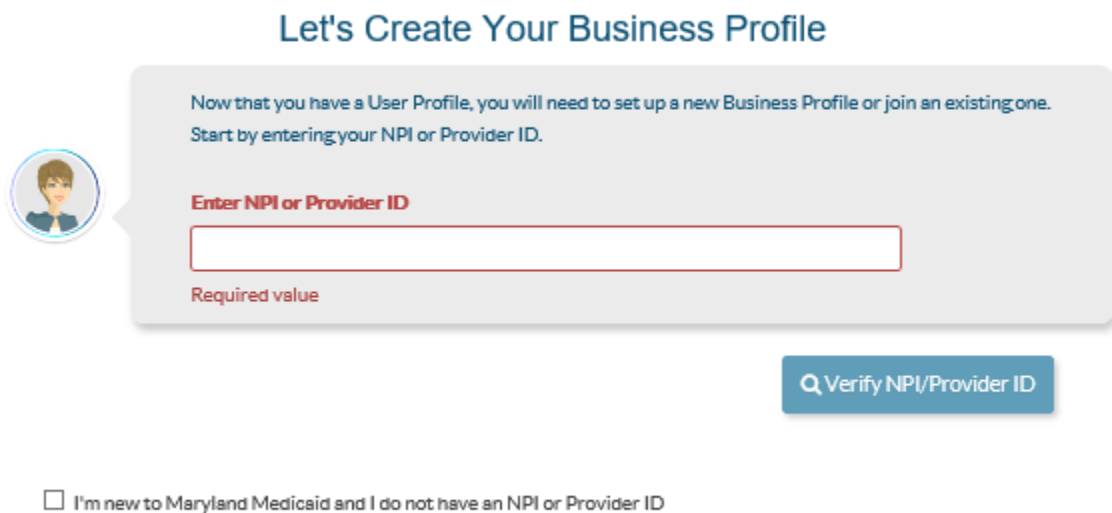
Next

WARNING!
You have accessed Maryland Medicaid's Internal Test Site - NOT Intended For Public Use
Applications submitted from this environment **WILL NOT** be processed by Maryland Medicaid.
To access Maryland Medicaid's Public Site [CLICK HERE](#)

ePREP Portal SSD Version: 4.0.1.5 - Build Number:180
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Snagit Capture

6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.



The screenshot shows the 'Let's Create Your Business Profile' screen. It features a large grey box with a speech bubble containing a user icon and the text: 'Now that you have a User Profile, you will need to set up a new Business Profile or join an existing one. Start by entering your NPI or Provider ID.' Below this is a red-bordered input field labeled 'Enter NPI or Provider ID' and 'Required value'. To the right of the input field is a blue button labeled 'Verify NPI/Provider ID'. At the bottom, there is a checkbox labeled 'I'm new to Maryland Medicaid and I do not have an NPI or Provider ID'.

Let's Create Your Business Profile

Now that you have a User Profile, you will need to set up a new Business Profile or join an existing one.
Start by entering your NPI or Provider ID.

Enter NPI or Provider ID

Required value

Verify NPI/Provider ID

☐ I'm new to Maryland Medicaid and I do not have an NPI or Provider ID

7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll

****This is the name that will be listed on your provider business profile.****

Let's Create Your Business Profile

Now that you have a User Profile, you will need to set up a new Business Profile or join an existing one. Start by entering your NPI or Provider ID.

Enter NPI or Provider ID

[Verify NPI/Provider ID](#)

Business Profile Name

[Required value](#)

[Create Business Profile](#)

☐ I'm new to Maryland Medicaid and I do not have an NPI or Provider ID

ePREP Portal
Version: 4.10.12.0 Build: #1235
© Copyright 2021 Digital Harbor Inc. All rights reserved.

8. Security questions portion: please select and correctly answer three corresponding security questions as they pertain to your business. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting “Next”.

You have 3 chances per session to answer correctly.

First Question

What is your date of birth?

Answer

Correct Answer

Second Question

What are the last 4 digits of your SSN?

Answer

Correct Answer

Third Question

What is your phone number for your service address?

Answer

Correct Answer

Congratulations!!

You had successfully linked your account(s) to your Business Profile.
To see your account(s) now [click here](#) or select continue to go

ePREP Portal
Version: 4.10.12.0 Build: #1235
© Copyright 2021 Digital Harbor Inc. All rights reserved.

****It's important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

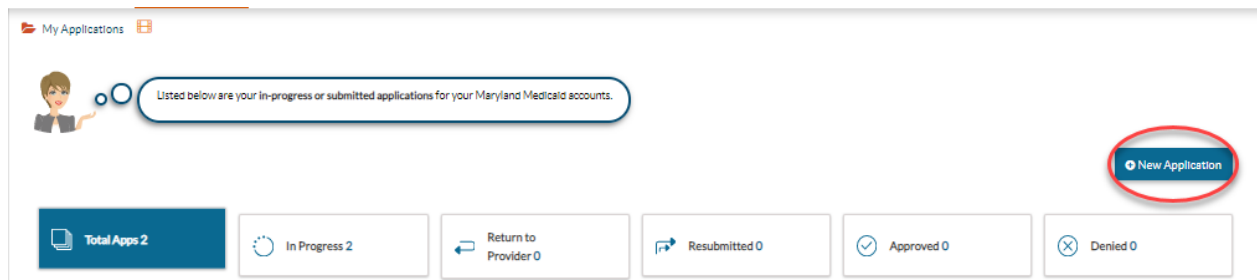
9. Once your business profile has been created, you will be taken to the e PREP home page

shown below:



10. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.

11. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. **Circled in the screenshot below.**



12. Application generation: once you have clicked the “New Application” tab, the following selection will need to take place in order to generate your enrollment application.

13. **Application generation selection:** please make the selections listed below:

- I'm new to Maryland Medicaid, and I want to create a new application
- I'm a group or FQHC health care practice
- Continue

The screenshot shows a web interface for the Maryland Medicaid application process. At the top, a progress bar has four steps: 'Start Application' (active, with a red circle), 'Business Structure', 'NPI', and 'Provider Type'. Below the progress bar, a blue-bordered callout box contains a greeting from 'Kellie' and instructions to answer a questionnaire to determine the correct application type. The main content area features a list of radio button options. The first three options are: 'I'm enrolled in Maryland Medicaid, and I want to create an application', 'I'm enrolled in Maryland Medicaid, and I want to affiliate with another provider', and 'I'm new to Maryland Medicaid, and I want to create a new application' (which is selected). Below the third option, a sub-question asks 'What kind of provider are you?' with three radio button choices: 'I'm an Individual health care practitioner', 'I'm a Group or FQHC health care practice' (which is selected), and 'I'm a Facility, Clinic, Health Care Organization or Walver Provider'. A fourth radio button option at the bottom is 'I want to make changes to my account'. At the bottom of the screen, there are two blue buttons: '← Previous' on the left and 'Continue →' on the right. A small instruction at the bottom left reads 'Once you have made your choice, select **Continue**.'

Start Application Business Structure NPI Provider Type

Hello, Kellie!

Please answer this simple questionnaire to help me to determine the correct type of application for you. If you need help with any of these options, you can watch the [Questionnaire in-context tutorial](#).

Let's get started!

☐ I'm enrolled in Maryland Medicaid, and I want to create an application

☐ I'm enrolled in Maryland Medicaid, and I want to affiliate with another provider

☒ I'm new to Maryland Medicaid, and I want to create a new application

What kind of provider are you?

☐ I'm an Individual health care practitioner

☒ I'm a Group or FQHC health care practice

☐ I'm a Facility, Clinic, Health Care Organization or Walver Provider.

☐ I want to make changes to my account

Once you have made your choice, select **Continue**.

← Previous Continue →

- Please select the Health Care Group option. Once selected, please select continue.

Start Application **Business Structure** NPI Provider Type

Great! Now select which business structure best fits your health care Group.

I need a Maryland Medicaid account to bill for healthcare services and I am applying as :

☒ I'm a Health Care Group

- I'll be using my **Type 2 NPI** (Organization)
- I have one or more affiliated health care professionals who render services
- My Group practice has one or more owners

☐ I'm a Federally Qualified Health Center (FQHC)

Once you have made your choice, select **Continue**

[< Previous](#) [Continue >](#)

- Once you have entered your NPI, please click the “verify” option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.

Start Application Business Structure **NPI** Provider Type

Okay, you have chosen Individual Solo Practitioner for your application. Please enter your Type 1 **National Provider Identifier (NPI)** that you want to use for this application, and select **Verify**.

National Provider Identifier (NPI)

[Required value](#) [Verify >](#)

When you have entered and verified your NPI, select **Continue**.

[< Previous](#) [Continue >](#)


- Provider type** - in the drop down box menu, please select the provider type **Doula** and click continue.

Start Application

Business Structure

NPI

Provider Type



Now that your NPI has been verified, select your Group's **Provider Type** from the drop-down list, and press **Continue** to move on.

Provider Type


DOULA

When you are ready, select Continue.

← Previous

Continue →

- **Successful Application Generation** - Once you have generated the application, you will be able to complete each required section from start to submission.



Provider Name

Provider Type

Application ID

Creation Date

Package Type

Nurse Midwife

2111597E

11/10/2021

Individual Billing

3% Complete

0% Documents

New Message

Submit

Content

Expand All

Getting Started

Getting Started

Profile Information

Business Information


Practice Information

Disclosure Information


Signature

Submit Application

Getting Started



In-Context Tutorials (ICTs) are available to **assist** in general areas of the Portal while filling out your application

Just look for the  icon.

Getting Started

Familiarize yourself with all the elements of this page, including:

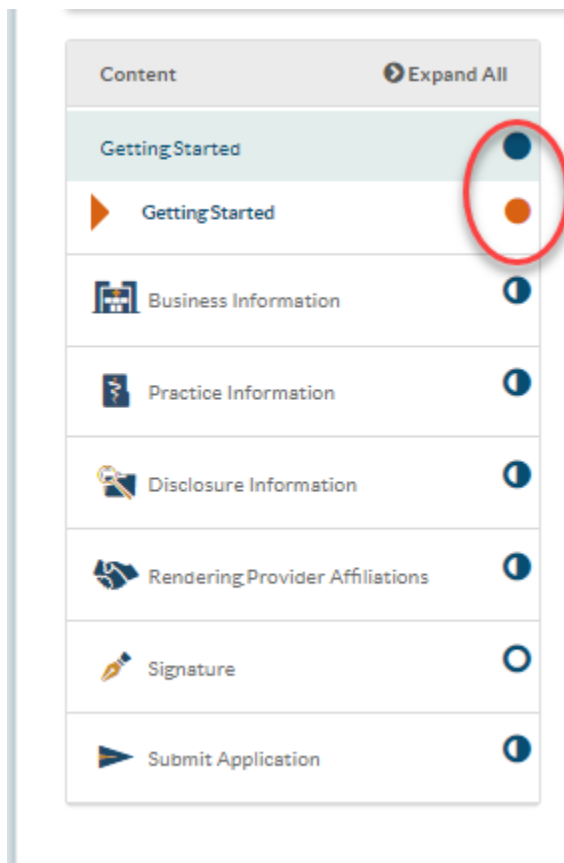
- Application structure
- Social tools
- Status indicators

Getting Started

Check out these other helpful ICTs for [Social Chat](#), [Explanations](#), [Share](#) and [Messages](#)

Continue →

14. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section.




15. **Business Information:**

Business Profile

TIN/SDAT & Business License

Summary



Please share some basic information about your business.

Legal name

Required value


Does your business use a registered Doing Business As (DBA) name?

☒ Yes
☐ No

DBA name

Required value

Doing Business As (DBA) statement



Drag and drop here or [browse](#)
 50MB Maximum

Entity type

<Select one>

☒

Required value

Business number

Required value

Extension

[Business Name goes here] Practice Website's URL

← Previous

Continue →

16. Please enter the business' legal name.

17. If you have a DBA name, please select "Yes", and attach the supporting documentation. If you do not have a DBA, please select "No" and click continue.

18. For Entity type, please choose the entity that best fits your organization. Please be prepared to upload all supporting documentation for this choice ex: Non-profit Organization requires a 501(c) be attached to the application.

Content

Expand All

Getting Started

Business Information

Business Profile

Contact Person

Addresses

Logistics

Practice Information

Disclosure Information

Rendering Provider Affiliations

Signature

Submit Application

Business Profile

TIN/SDAT & Business License

Summary

Please share some basic information about your business.

Legal name

MDH HOME VISITING SERVICES

Does your business use a registered Doing Business As (DBA) name?

☐ Yes
☒ No

Entity type

Non-profit Organization 501(c)

NPO - Non-profit Organization 501(c)

Drag and drop here or [browse](#)

50MB Maximum

Business number

Required value

Extension

Practice

Website's URL

Previous

Continue

19. Enter the business number.

20. Please click continue

21. This is the TIN/SDAT Business License page. Please click on the TIN/EIN paperclip. Please upload the Tax ID Letter for your group.

MA Number: 150752800

Content Expand All

- Getting Started
- Business Information
- Business Profile
 - Contact Person
 - Addresses
 - Logistics
- Practice Information
- Disclosure Information
- Rendering Provider Affiliations
- Signature
- Submit Application

Business Profile TIN/SDAT & Business License Summary

I need some additional information about your business. Don't forget to attach a clear copy of your documentation.

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) 04-292****

☐ N/A

State Department of Assessment and Taxation (SDAT) number

Required value

22. Please click on the 'Select your file' button to upload the TIN/EIN document and name your document in the 'Document Name' box.

Example of TIN/EIN Letter:

Date of this notice: [REDACTED]

Employer Identification Number: [REDACTED]

Form: [REDACTED]

Number of this notice: [REDACTED]

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [REDACTED]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

- * Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
- * Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
- * Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.


Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

Business Profile

TIN/SDAT & Business License

Summary




I need some additional information about your business. Don't forget to attach a clear copy of your documentation.

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

Required value

TIN/EIN

 Drag and drop here or [browse](#)
50MB Maximum

☐ N/A

Required value

State Department of Assessment and Taxation (SDAT) number

Required value

← Previous


Continue →

23. For the State department of Assessment and Taxation (SDAT) number, please enter your business SDAT number.

- Providers are required to obtain and disclose their SDAT number on all applications that request it. Please do not check 'N/A'.

Contact Person Information

Summary



Who should I contact if I have questions about your application?
Please choose a contact person who will be available during regular business hours.

☐ I, Hazel Abinsay will be the contact person

First name

Required value

Last name

Required value

Title/Position

Business number

Required value

Extension

Fax Number

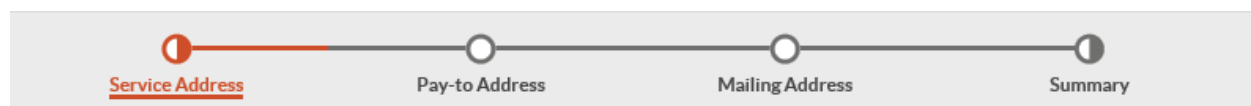
Correspondence email address

Required value

← Previous

Continue →

24. This is the Contact Person Information Page. Please be sure to fill out the contact information correctly. **The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person.**



Your Maryland Medicaid account is based on the location where health care services will be provided. As you type, a suggested address will appear that can auto-fill the rest of the form for you. Remember that a P.O. box cannot be used as a service address.

[View Address](#)

Street

Address Line 1

Required value

Suite / Apt. #

Suite/Apt

City

City

Required value

State/Province

Maryland, MD ☐

County

County

Required value

ZIP Code/Postal Code

96819-4000

Is this service location ADA (American Disabilities Act) accessible?

☐ Yes ☐ No

Required value



Does this service location have TTY capability?

☐ Yes ☐ No

Required value



[← Previous](#)

[Continue →](#)

25. Please fill out the service address.

Is this service location ADA (American Disabilities Act) accessible?

☐ Yes ☐ No

Required value

Does this service location have TTY capability?

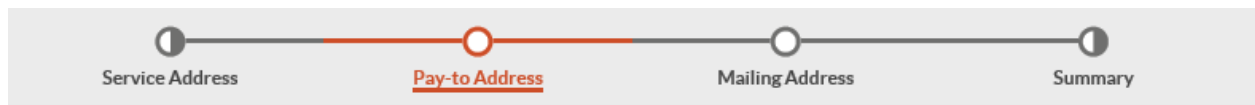
☐ Yes ☐ No

Required value

[← Previous](#)

[Continue →](#)

26. Please answer the following yes or no questions



Please let me know the address where you want to receive payments.

☐ Same as Service address

[View Address](#)

Street

Address Line 1

Required value

Ste. / Apt. #

Suite/Apt

City

City

Required value

State/Province

<Select a State>



Required value

County

County

Required value

ZIP Code/Postal Code

ZIP Code/Postal Code

Required value

[← Previous](#)

[Continue →](#)


27. Please fill out the Pay to Address of the location. (If you are not registered for EFT, this is the address the payment will be sent to.)

Service Address

Pay-to Address

Mailing Address

Summary



Last step! Add a mailing address where you want receive official Maryland Medicaid correspondence.

☐ Same as Service address

[View Address](#)

Street

Address Line 1

Required value

Ste. / Apt. #

Suite/Apt

City

City

Required value

State/Province

<Select a State>

Required value

County

County

Required value

ZIP Code/Postal Code

ZIP Code/Postal Code

Required value

Previous

Continue

28. Please fill out the Mailing Address for the location. **If there is a specific person that needs correspondence, please identify them in the Ste./Apt.#. Please say ATTN:LAST NAME, FIRST NAME**

29. Please answer the following yes or no questions.

30. What are the business hours for this business location?

a. If you are open 24/7, please check the box.

b. If you are a business that has specific hours of operation, please list them here.

What are the business hours for this service location?

☐ Open 24/7

☐ Open on specific business days/hours

Required value

31. Has the staff of (Organization) completed cultural competency training? Please answer 'yes' or 'no'.

Has completed a cultural competence training?

☐ Yes ☐ No

Required value

32. Is (Organization) accepting new patients? Please answer 'yes' or 'no' as it pertains to your business.

Is accepting new patients?

☐ Yes ☐ No

Required value

33. What is the age range of the patients that will be treated at this service location?

What is the age range of the patients that will be treated at this service location?

☐ Enter age range

☐ All ages

Required value

34. Does (Organization) see fee-for-services (FFS) Medicaid participants?
Please answer 'yes' or 'no' as it pertains to your organization.

Does see fee-for-service (FFS) Medicaid participants?

☐ Yes

☐ No, I only accept HealthChoice managed care patients

Required value

35. Does (Organization) provide language services to their patients, other than English, at this location?




a.If "yes," please list all other languages in this section.

Does _____ provide language services to their patients, other than English, at this location?

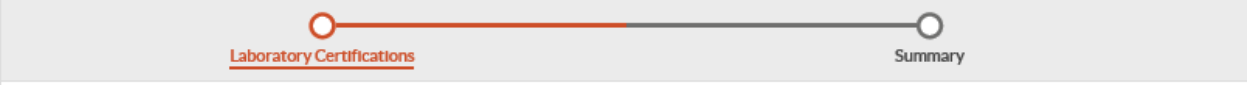
☐ Yes ☐ No


Required value

36. Once you have completed filling out all of the Business Information, the circle will be completely filled in.

| Content | Expand All |
|--|---|
| Getting Started |  |
|  Business Information |  |

37. Practice Information Section:





Here's where you can attach all of your professional licenses and certificates. Please provide **clear copies** so my analysts can read them.

Will _____ bill for laboratory services provided to Maryland Medicaid participants at this location?

☐ Yes ☐ No

Required value

88

Previous

Continue

- Please answer yes or no to the question above.



Here's where you can attach all of your professional licenses and certificates. Please provide **clear copies** so my analysts can read them.

Will Name of the applicant not provided bill for laboratory services provided to Maryland Medicaid participants at this location? ☒ Yes ☐ No 88

CLIA number

Required value

CLIA Certificate




Drag and drop here or [browse](#)
50MB Maximum

MD Lab Permit Number

☐ N/A

Required value

MD Lab permit number



Drag and drop here or [browse](#)
50MB Maximum

☐ I do provide pathology and/or pulmonary labs at this location

Do you provide medical laboratory services for your own patients?

☐ Yes ☐ No

Required value

88

Do you provide medical laboratory services for other than your own patients?

☐ Yes ☐ No

Required value

88

Do you receive specimens that are obtained from other sites located in Maryland?

☐ Yes ☐ No

Required value

88

- If yes, please provide the document numbers and upload the appropriate certificates for the business' CLIA and MD Lab permit in this section.
- Please answer 'yes' or 'no' to the three questions that follow.

38. This is the NPI/ Taxonomy/ Specialty page. Please double check that the NPI listed on this page is correct.

- Taxonomy code should match what is in NPPES
- If the organization has any additional specialty codes, please list them here.

Business Information

Practice Information

Licenses & Certifications

NPI/Taxonomy/Specialty

Additional Information

Disclosure Information

Rendering Provider Affiliations

Signature

Submit Application

Great work! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI)

Associated Taxonomy Codes

Add

| Description | Taxonomy Code | Type | Actions |
|--------------------------|---------------|------|---------|
| No taxonomy code listed. | | | |

Associated Specialty Codes

☐ N/A

Add

| Specialty Code | Description | Type | Actions |
|---------------------------|-------------|------|---------|
| No Specialty code listed. | | | |

39. Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.

Add Taxonomy Code

Taxonomy code

<Select a value>

Required value

Type

☒ Primary ☐ Secondary

+ Add

✕ Cancel

Business Information

Practice Information

Licenses & Certifications

NPI/Taxonomy/Specialty

Additional Information

Disclosure Information

Rendering Provider Affiliations

Signature

Submit Application

Great work! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI)

Associated Taxonomy Codes

| Description | Taxonomy Code | Type | Actions |
|-------------|---------------|---------|---------|
| Doula | 374J00000X | Primary | |

Associated Specialty Codes

☐ N/A

| Specialty Code | Description | Type | Actions |
|---------------------------|-------------|------|---------|
| No Specialty code listed. | | | |

40. This is the Addenda/ Supporting Documents page. Please be sure to attach the 'Medical Assistance Program Application Facility / Organization: **PT DL: Doula** is the correct addenda needing to be attached to this section of the application.

Addenda/Supporting Documents

Summary

The provider type Local Education Agencies/Local Lead Agency requires addenda and supporting documents to be attached to this application.

Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.

☐ N/A

Addenda/Supporting Document Name
Documents
Actions

There is no addenda

Previous

Continue

You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

<https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx>

Addendum Example:



Addendum for Maryland Medical Assistance Program Application PROVIDER

Doula/Birth worker - PT DL

If you have questions, please contact the Provider Enrollment Helpline at 1-844-4MD-PROV (1-844-463-7768)
Monday – Friday from 7am – 7pm.

All providers are required to use the electronic Provider Revalidation and Enrollment Portal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Group Doula Attestation Form. Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Date of Attestation Submission: __/__/__

Attestation of Certification [Check all certifying organizations that you accept from your doulas in order to provide services]

- ☐ Ancient Song Doula Services
 - ☐ Full Spectrum Labor & Postpartum Certification
- ☐ Childbirth International (CBI)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certifications
- ☐ The Childbirth and Postpartum Professional Association (CAPP):
 - ☐ Certified Labor Doula
 - ☐ Certified Postpartum Doula
 - ☐ Certified Community Lactation Educator Certification
- ☐ Doulas of North America (DONA)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certification
- ☐ Doula Trainings International:
 - ☐ Full Spectrum Doula Certification
 - ☐ OR (Birth Doula Certification and Postpartum Doula Certification)
- ☐ The International Black Doula Institute (IBDI):
 - ☐ Pregnancy & Childbirth Doula Certification,
 - ☐ Postpartum & Newborn Certification
 - ☐ Lactation/Breastfeeding Certificate of Completion
- ☐ International Childbirth Education Association (ICEA)
 - ☐ Birth Doula Certification
 - ☐ Postpartum Doula Certification
- ☐ Mamatoto Village
 - ☐ Community Birth Worker Certification
- ☐ MaternityWise:
 - ☐ Labor Doula Certification
 - ☐ Postpartum Doula Certification



Addendum for Maryland Medical Assistance Program Application PROVIDER

Doula/Birth worker - PT DL

Attestation of Doula Program Certification [Check all that apply]

- ☐ The **organization** attests that all employed doulas have successfully obtained one of the certifications checked above, and have exhibited the competencies necessary to deliver doula services.

AND

- ☐ The **organization** maintains a typed roster of all doulas who are in good standing, which includes each doula's full name, NPI number (optional), birth date, and Social Security Number; with proof of their qualifications as described above, and will be able to provide supporting documentation if requested by MDH.

Attestation of Liability Insurance [Check one]

- ☐ Yes, **my organization** requires adequate liability insurance for each doula.
☐ No. If no, please attach explanation.

Attestation of Fingerprint Criminal Background Check Completion

- ☐ I understand that all doula providers have passed a Fingerprint Criminal Background Check (FCBC).

Snipping Tool

The screenshot shows a web application interface with a sidebar on the left containing links for 'Business Information', 'Practice Information', and 'Licenses & Certifications'. The main content area displays a message: 'The provider type Local Education Agencies/Local Lead Agency requires addenda and supporting documents to be [attached to this application](#).' Below this message is a link: 'Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the...'. A modal dialog box titled 'Addenda/Supporting Document' is open in the center. It has a text input field labeled 'Addenda/Supporting Document Name' containing the text 'Addenda'. At the bottom right of the dialog are two buttons: '+ Add' and 'x Cancel'.

41. Please click on the 'Add' button to name the Addendum.

Upload Document



Drag and drop here, or [Select your file ...](#)

File size can not be greater than 50 MB

Please note that in order for your document to be reviewed, you must remove any passwords that have been used to keep it secure.

Section Name

Addenda/Supporting Documents

Document Name

Title

Required value

Description

☒ Share it in Document Library.

☒ This is a sensitive document.


Attach

Cancel

42. Please click 'Add' again to upload the Addendum.

Addenda/Supporting Documents

Summary






The provider type Local Education Agencies/Local Lead Agency **requires** addenda and supporting documents to be attached to this application.

Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.

☐ N/A

Add

| Addenda/Supporting Document Name | Documents | Actions |
|----------------------------------|--|--|
| Facility/ Organization |  <div>Addenda/Supporting Document</div> <div>document is required</div> |   |

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43. Once the Addendum is uploaded, please click continue.

Has [REDACTED] been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid program in Maryland or in any other State, Medicare, or any governmental or private medical insurance program?

☐ Yes ☒ No



Has [REDACTED] ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense against public administration or against public health and morals in any State?

☐ Yes ☒ No



Has [REDACTED] ever been found liable for fraud or abuse involving a government program in any civil proceeding?

☐ Yes ☒ No



Has [REDACTED] ever entered into a settlement to resolve a proceeding related to fraud or abuse involving a government program?

☐ Yes ☒ No



Has [REDACTED] ever had their business or professional license or certification suspended, surrendered, or in any way restricted by probation or agreements by any licensing authority in the state?

☐ Yes ☒ No



Are there currently **any proceedings** that could result in the above-stated **sanctions**?


☐ Yes ☒ No



44. This is the 'Adverse Action' page. Please fill out any adverse action information.

Fines and Debts (Gov.)

Summary



If you have any fines or debts to any organization related to Medicare, Medicaid or any other federal or state health care programs, please let me know of your payment arrangements.

☐ This business has no current State or Federal government Fines/Debts

Add

| Type | Agency Name | Amount | Date Issued | Date to be Paid-in-full | Documents | Actions |
|-----------------------|-------------|--------|-------------|-------------------------|-----------|---------|
| No Fines/Debts listed | | | | | | |


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45. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has.

Subcontractors

Summary



Awsome, [redacted]! This part is even simpler. It's related to any subcontractors you may or may not have.

Does [redacted] have any subcontractors to which the applicant has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies or with whom the applicant has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Maryland Medicaid Program?

☐ Yes
 ☐ No

Required value

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 - Fines and Debts (Gov.)
 - Subcontractors
 - Control Interest
 - Significant Transactions
 - Delegated Officials
- Signature
- Submit Application

Control Interest Summary

Please let me know about any individuals who have control interest in your practice.

Are there any Individuals who have Control Interest in [redacted]?

All board members, corporate officers, directors, agents, and managing employees of [redacted] must be reported in this section as well.

☐ This business has no current individuals with Direct or Indirect Control Interest

+ Add

| Type | Name | Control Interest | Status | Actions |
|---------------------------------------|------|------------------|--------|---------|
| No Ownership Control Interest listed. | | | | |

← Previous **Continue →**

46. This is the Ownership/ Control Interest page. Please click 'Add.' Please enter the provider name and address.

Add Ownership/Control Interest ×

☐ Entity ☐ Individual

Required value:

+ Add **× Cancel**

47. Please identify if the organization is owned by an entity or an individual.

Add Ownership/Control Interest



☐ Entity ☒ Individual

First name

Required value

Middle name

Last name

Required value

+ Add

✕ Cancel

48. With either the entity or individual, please identify their name.

| Profile Information | Please enter the following information |
|--------------------------|--|
| Business Information | First name <input type="text" value="Allyson"/> |
| Practice Information | Middle name <input type="text"/> |
| Disclosure Information | Last name <input type="text" value="League"/> |
| Adverse Actions | Social Security Number <input type="text" value="--- --"/> |
| Fines and Debts (Gov.) | Date of birth <input type="text" value="--/--"/> |
| Subcontractors | Age <input type="text"/> |
| Control Interest | National Provider Identification (NPI) <input type="checkbox"/> N/A |
| Significant Transactions | Primary Residence Address |
| Delegated Officials | View Address |
| Signature | Street <input type="text" value="Address Line 1"/> |
| Submit Application | Ste. / Apt. # <input type="text" value="Suite/Apt"/> |
| | City <input type="text" value="City"/> |
| | State/Province <input type="text" value="Select a State"/> |
| | County <input type="text" value="County"/> |
| | ZIP Code/Postal Code <input type="text" value="ZIP Code/Postal Code"/> |

Does Allyson League currently participate or has ever participated as a provider in the Maryland Medicaid program or in another states' Medicaid program? ☐ Yes ☐ No

Required value

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49. Please fill out the ownership individual/entity information.

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Adverse Actions

Summary

Please select one or more of the options that apply to Allyson League

☐ Board Member

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☐ Managing Employee

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☐ Agent

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☐ Director/Officer

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☐ Other

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Summary

Associations/Family relations with subcontractors and owners of subcontractors

Ownership of 5% or more on any subcontractor

Does Allyson League have ownership with any of subcontractors disclosed in this application?

☐ Yes
☐ No

Required value

88

Family Relations with subcontractor or subcontractor's owner(s)

Does Allyson League have family relations with any of subcontractors disclosed in this application?

☐ Yes
☐ No

Required value

88

Does Allyson League have any family relations with any owner(s) of subcontractors?

☐ Yes
☐ No

Required value

88

Associations/Family Relations with Individuals (owners/control interest of Applicant)

Is Allyson League affiliated with any Entities or is family related to any Individuals disclosed in this application?

☐ Yes
☐ No

Required value

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Other Associations

Does Allyson League have any ownership or Control Interest in any other health care provider participating or not participating in Maryland Medicaid?

☐ Yes
☐ No

Required value

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50. Please answer the “yes” or “no” questions about the ownership entity or individual.

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Significant Transactions

Summary

Please carefully read this question and answer accordingly.

I, , agree that upon request by the Secretary of the Maryland Department of Health, or the Maryland Department of Health, full and complete information will be supplied **within 35 days** of the date of request, concerning:

☐ Yes ☐ No

Required value

A. The ownership of any subcontractor with which the Title XIX Provider has had, during the **previous 12 months**, business transactions in an aggregate amount in **excess of \$25,000.00** and

B. Any significant business transactions, occurring during the **5 year period** ending on the date of such request, **between** the provider and any wholly-owned supplier or subcontractor.

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51. This is the 'Significant Transactions' page. Please mark 'yes' to the following question.

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Delegated Officials

Summary

Here's where you can designate all Delegated Officials for your health care business. A Delegated Official is either 1) an individual with ownership/control interest or 2) a W-2 employee (not a contractor) to whom you wish to give authorization to sign Affiliate applications on behalf of your Group or Organization.

Adding a Delegated Official is optional. If you choose not to add one, that means only your Group/Organization's authorized individuals may sign Affiliate applications.

☐ does not want to report any Delegated Officials at this time.

[Add](#)

| Legal Name | Reported by | Added Date | Last Update | Status | Actions |
|--------------------------------|-------------|------------|-------------|--------|---------|
| No Delegated Officials listed. | | | | | |

☐ A DELEGATED OFFICIAL means an individual who is delegated the authority to sign on behalf of the applicant or provider by an authorized official for situations as specified in the provider bulletin titled Requirements and Procedures for Groups Designating Delegated Officials. The delegated official must be an individual with Ownership or control interest in, or be a W-2 Employee of, the provider or applicant. An independent contractor cannot be a delegated official.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the entity's Maryland Medicaid enrollment information. The authorized official will still retain the authority to make changes and/or updates, even if a delegated official is appointed.

A provider or applicant is not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to enrollment information.

Signatures provided by delegated officials shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider or applicant to the laws, regulations, provider bulletins and program instructions of the Maryland Medicaid program.

By his or her signature on affiliation forms, a delegated official certifies that the individual has read the Maryland Medicaid Provider Agreement, and all information in the affiliation form and agrees to adhere to all the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official as defined in provider bulletin titled Requirements and Procedures for Groups Designating Delegated Officials. The delegated official certifies under penalty of.

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52. Please identify any delegated officials.

Rendering Provider Affiliations
Summary

Please disclose each Rendering provider affiliation by selecting **Add Rendering** (at least one is required).

If an individual is disclosed in the Ownership/Control Interest sub-form **and** renders services at this location, they **must** also be added as a Rendering provider.

[Add Rendering](#)

| Application ID | App Status | Rendering Name | Provider Type | NPI | Status | Actions |
|------------------------|------------|----------------|---------------|-----|--------|---------|
| No affiliations listed | | | | | | |

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53. Please identify any rendering provider affiliates. If all rendering providers are now affiliated, no action is required. If there are any new rendering providers that need to be affiliated, please do so at this time.

54. If there are no organizational affiliations, please click 'No.'

55. If the organization does have affiliations, please click 'Yes' and add any needed information.

56. Once onto the signature portion, please fill out the required information and click submit.

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- E-Signature
- Submit Application

Declarations E-Signature Summary

You're almost ready to sign your application!

Even though you're completing and submitting your application through ePREP Portal and not on paper, your signature is still required. Using the electronic signature feature, you can submit this application just like your handwritten signature.

Please read the Maryland Medicaid Provider Agreement, and then check the boxes to declare that you agree with this process.

Please note that in order to continue with the e-Signature process, you must read the Provider Agreement.

[Maryland Medicaid Provider Agreement](#)

☒ I, Allyson League, have read, understood, and agree with the terms of the Maryland Medicaid Provider Agreement.

☒ I, Allyson League, declare that I have legal authorization to sign this application for and on behalf of MDH HOME VISITING SERVICES.

☒ I, Allyson League, have reviewed my application and believe all information and attachments are correct to the best of my knowledge.

☒ I, Allyson League, declare under penalty of perjury under the laws of Maryland that the foregoing information and the information on all attachments is true, accurate and complete, to the best of my knowledge and belief, and that I am authorized to sign this application pursuant to State Regulations.

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Declarations

E-Signature

Summary

To continue with the e-Signature process, I need to verify your personal information.

After agreeing to the declaration, make sure your Social Security Number and Date of Birth are identical to what you entered in the Personal Information section of the Ownership/Control Interest sub-form.

Please treat this section the same way as if you were using your PIN at an ATM.

If you need help with this section, please watch this In-Context Tutorial about e-signing a Facility application.

☒ I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-206.

88

SSN (last 4 digits)

###-##-____

Required value

Year of birth

##/##/____

Required value

Email address

allyson.league@maryland.gov

Password

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Checklist

Submit

Submit Application

Almost finished! Before you submit Allyson League application, you may want to review the most common mistakes made that cause these applications to be deficient. To review the common mistakes, select the "Show Me" button below.

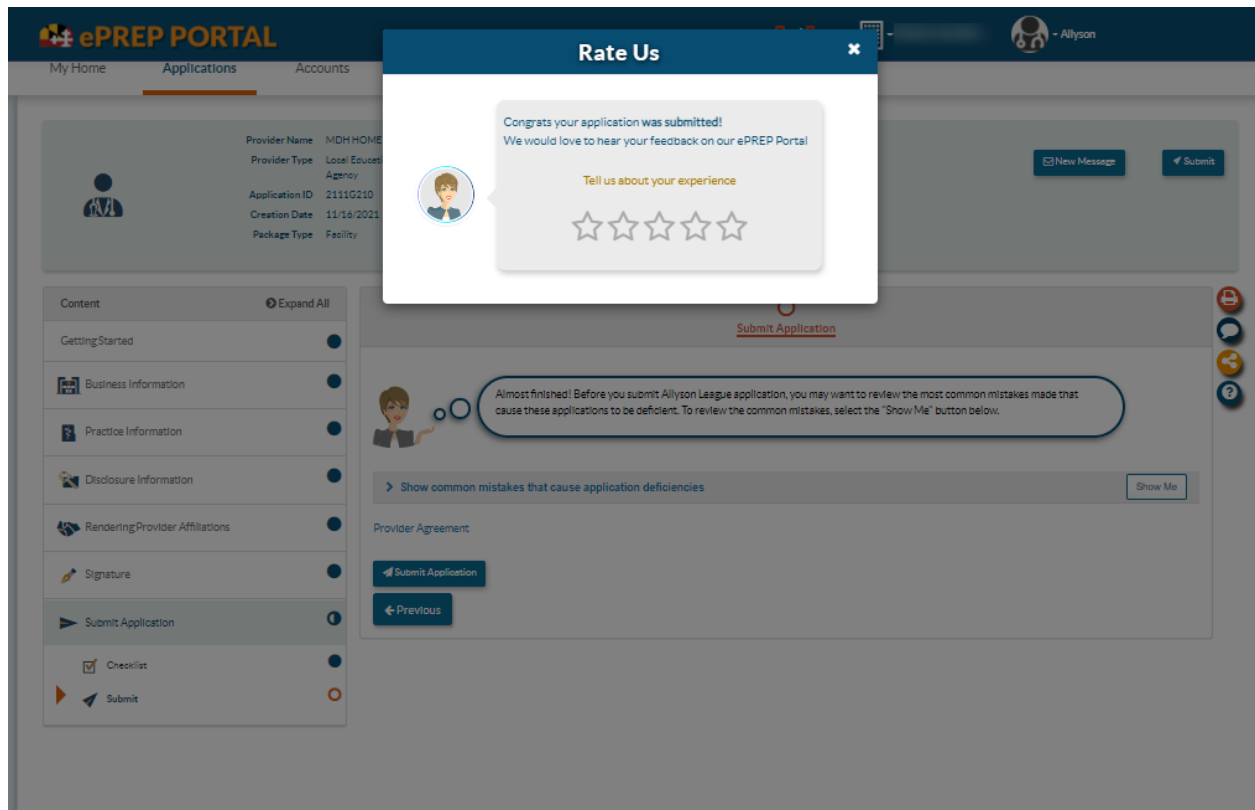
Show common mistakes that cause application deficiencies

Show Me

Provider Agreement

Submit Application

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Please feel free to rate the ePREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at
mdh.providerenrollment@maryland.gov